THE USE OF THE CURRETTE

IN

UTERINE SURGERY,

BY

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The Use of the Currette in Uterine Surgery.

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I am aware that in many respects this subject is not a new one to my hearers, and that I am approaching dangerously near to the point of "Carrying coals to Newcastle," yet I am convinced that there is still in the theme much that can be discussed to our mutual good.

First. As to the class of cases that come to the general practitioner in which this line of treatment is to be employed. I am not one of that number whose dogma seems to be that everything special ought to go to a specialist, but rather that the general practitioner must, in many situations, and under many surroundings, act the part of a specialist, doing that which the immediate present calls for, and then when his skill or opportunities tell him clearly that he has exhausted his powers, to send for, or send his patient to the specialist. In this way I am sure the number of chronic invalids will be reduced to the minimum and much suffering avoided. The duty of the general practitioner becomes greater, with each advance made in every department or specialty, in medicine or surgery. He must learn to recognize and diagnose his case if nothing more. In like manner the specialist has resting upon him the great responsibility. His superior advantages, originally given and maintained by his brother, the general practitioner,—in his bestowal of confidence—demand that he make so clear his diagnosis and alignment of cases as to aid and not mystify.

Now as to the class of cases: Begin with the young girl; she has her constant hemorrhage at the commencement of menstruation. She is the favorite daughter of one of your best families; her parents are your best supporters in many ways, or, she is the daughter of the skilled mechanic, the plain, outspoken farmer, the widowed mother, the orphan; in other ways the humblest one in the walks of life. To the skill of the physician each should present like claims to the careful investigation of the case. It is determined, and rightly, that all medical treatment be first exhausted—medicines, massaging, electricity, climate, all, as far as possible, be tried, and I repeat that this is proper, for I am strongly of the faith that no young girl should be subjected to a pelvic, vaginal examination until it becomes absolutely necessary. But she does not recover. Now, by an examination, under an anæsthetic—as is necessary in many of these cases—there is found some form of flexion, with an enlargement of the body of the uterus, tender and sensitive to the touch, or, there is a stenosis of either the external or internal opening of the cervical canal, with partially retained menstrual flux, or there is a polypus present, or, in a lesser degree, that condition denominated endometritis fungosa, or, as the result of some illness, some injury, a traumatism of any kind, a pelvic peritonitis, your patient has that condition denominated in the text-books chronic endometritis. These are only a portion of like conditions you find in your cases, when once you determine upon a thorough physical examination. These are the cases I submit in all candor as proper ones to be treated by the use of the currette.

To illustrate: Mrs. L., aged twenty-six, whom I saw March 19, 1892; married six weeks; was a patient of mine previous to her marriage; had suffered more or less for a period of eight years from continued leucorrhœa, and always an increased flow, more than normal, at her menstrual period, at times amounting to a hemorrhage. I had frequently urged upon them the necessity for an examination, but this she and her parents declined. She would sometimes improve under tonics, change of air and scenery, but only to relapse again

when going on with her society work and household duties. After consulting with her husband, she concluded to have a thorough examination. I found a marked erosion of the cervix, retroflexion, a small polypus, and a most intense vaginitis, the vagina filled with granulating tissue. The parts were thoroughly cleansed, packed with iodoform gauze, followed by great improvement, and finally she went on to recovery.

This group extends from the young girl, through school life into womanhood, perhaps to become the maiden who is known as the delicate one in the family, to be placed in bed a certain number of days in each month—not a great inconvenience to some, to others a loss of time, of labor, to be measured by the bread and butter standard—or to throw upon some other member of the family a greater strain and possible illness in that one to follow. In the interval of an improvement, that has been brought about by great perseverance of treatment, a marriage is contracted, and perhaps a pregnancy becomes the currette that to this patient brings health. Her friends are joyous, she looks and appears so much better since the baby came. But there is another side to this class of cases. The marriage does not result so fortunately. The young wife, anxious to please her hnsband in social life, does her utmost, and but too often the extra exertion brings on that strain which increases the serious symptoms that ultimately terminate in a collapse. A trip abroad does very little good. Alas—tissue changes have occurred. The case now, that could have been treated successfully by comparatively safe and simple means, has associated with it diseased tubes, and in some form, probably, diseased ovaries. The husband tires of treating his young and invalid wife; she returns home, he elsewhere, or, if he is of the better portion of humanity, he has before him a long and expensive line of treatment in bringing back to health his dear one. If the marriage be in and among another walk in life, the poor, honest, loving husband gives of his sympathy and means all that he can, too often to remain in dire distress, recovering from it only in such cases as where health is restored by some fortunate, formidable operation.

The husband of another class shows his brutal nature too often by indulgence in drink, by immoral conduct, the latter condition bringing to his wife additional suffering, at last to abandon her, or she to live on the most miserable of lives, the wife of a dissipated and cruel man.

Second. Another class presents, particularly in the married. She was comparatively well until the birth of her first child. Now, either from want of proper care, or indiscretion on her part, she has a slow getting-up; she moves on in society, or she continues her household duties, her mill work or otherwise, as the case may be, but she is not well. She fades in her beauty of person, and every duty in life becomes irksome. At last a careful examination is made and there is found subinvolution (chronic metritis) in a marked degree, a version or flexion is present, with all its attendant troubles, a lacerated cervix, possibly a polypus, perhaps nothing more than a well-marked endometritis that has followed her previous miscarriage or full-term coufinement.

Third. Another class that presents in a much more prompt and acute form. The miscarriage or confinement is over; it may have been instrumental, it may have been complicated by retained placenta, in portions or otherwise; at the end of the second, third or fourth day she has a chill, and rise in temperature, with other symptoms familiar to you all. Some of the older writers, and too many of our text-books diagnose the case as puerperal fever. The old nurse, the good women among the relatives say she has the lying-in fever, a few more advanced, say blood poisoning. We think of what? Pyemia, septicæmia, sapræmia, conditions that worry and alarm us; we make a careful examination; there is some laceration of the cervix, possibly more or less severe, a marked tenderness of the body of the uterus and cervical canal, a nasty, unpleasant discharge; a hot vagina, and many other symptoms with which you are familiarly acquainted.

Let the following case illustrate: Mrs. W., aged twenty-four, whom I saw January 11, 1891. Presented an excellent appearance of health; had been confined of a healthy child five days previously; labor apparently normal in every

respect. At the end of the second day she developed a temperature of 101 which increased each day, with pulse 120 and an offensive discharge from the vagina. When I saw her with her family physician, Dr. Bigelow, her temperature was 104. She was indifferent to all about her; said she felt easy and wanted to be left alone and sleep. There was no marked tenderness over the abdomen; no distension; uterus was somewhat soft to the touch. Immediate preparation was made for a thorough curretting. She was given a very small amount of ether and the operation performed in the most complete manner possible. In eight hours her temperature was down to normal, pulse ninety-six, she was bright and cheerful, and went on to uninterrupted recovery. Has since been confined of another child and everything passed off in a perfectly normal manner. I removed in this curretting more than an ounce of granular fungoid-like growth-proliferating cells from endometritis—and no doubt had not some active interference been instituted the case would have gone on to complete puerperal fever and probable death. I know of no one operation bringing about more pleasing results than a case like this.

But just here let me warn you, in a case like this, when you have once curretted the uterus thoroughly, not to be led into the error of flushing it with so-called antiseptic solutions, such as carbolic acid and mercurials. The following case is so much to the point that I feel to copy it:

Krukenberg (Zeitsch. f. Gynak., Band xxi., Heft) describes a case of poisoning from a 2.7 per cent solution of carbolic acid injected into the uterus of a multipara who had aborted, after some necrotic decidua had been brought away by curretting. The pulse suddenly failed while the injection was being given; then, as the pulse improved, the breathing ceased, which, after a time, was overcome by artificial respiration. Death followed ten days later, the post-mortem showing acute parenchymatous nephritis with endocarditis. The case once more proves the grave dangers of employing poisonous antiseptics in washing out the puerperal uterus.

It cannot be denied that some of these cases have and do recover without curretting, yet in what manner? Without doubt by the way of damaged tubes, pyosalpinx, ultimately to result in their removal by an operation that ought always to be avoided, if possible. Or a pelvic abscess that finds its way either into the bladder, vagina or intestinal tract, bringing with it a long train of invalid symptoms, perhaps ultimately a severe operation. Or a more sudden and serious termination—rupture into the peritoneal cavity, and death from shock, and collapse or purulent septic peritonitis. These last conditions, just mentioned, I am sure could often be averted by a prompt, careful but thorough curretting. The streptococci have not yet entered the tubes, and their march can be arrested. On this subject I would refer to a very valuable paper by Dr. Ernest Laplace, of Philadelphia, read in the section of Obstetrics and Diseases of Women at the American Medical Association at Detroit, June, 1892.

Fourth. Another class of cases perhaps occurring at any time in life, married or single, but more particularly after twenty-eight or thirty years of age up to, and including, the menopause are as follows:

A menorrhagia first then a prolonged metrorrhagia, at times almost a constant flow. On examination there is found a polypus, projecting from the uterus, or a fibroid, large or small, but presenting a bleeding surface, a sub-mucous or interstitial variety. The polypus is removed by snare or ecraseur, but the hemorrhage is not fully controlled—the cervical canal should have been curretted.

The fibroid is small, it seems hardly necessary to subject the patient to so severe an operation as removal of the uterine appendages, or supravaginal hysterectomy. A thorough curretting is safely done, the hemorrhage is controlled, menstruation becomes normal and occasionally the tumor disappears, precisely as these tumors do sometimes under the influence of pregnancy. Let me emphasize the former by a case from my notes, and also the latter by another case.

Miss P., aged forty-four, suffered for eight years from pretty continuous hemorrhage, due to a uterine fibroid. Had

had all manner of treatment with drugs, electricity, etc. I saw her June 26, 1882, and found her suffering from an interstitial fibroid, apparently the size of a large orange. She was very anæmic, somewhat emaciated, unable to move about, and herself and friends had little hope of her recovery. I suggested a thorough curretting with the hope of arresting the hemorrhage in that way, trusting that as she was so near her menopause if the hemorrhage could be controlled she would yet go on to recovery. The curretting had some beneficial effect in the immediate control of the bleeding, but at the end of ten days she was taken with severe uterine contractions, expelled the tumor, in the form of a polypus, into the vagina, and which I had very little trouble in removing. From this time she made an excellent recovery, and is now in the best of health. I have no doubt that curretting loosened the capsule so that the uterus was able to grasp and throw off the tumor in this way.

Mrs. C., aged thirty-two, In her second confinement her child was delivered, but her physicians were unable to remove the placenta, and I was sent for. I found her with the lower segment of the uterus empty, but the upper portion of the fundus retained the placenta, which I did not have very much trouble in removing, but found that she had a uterine fibroid the size and shape of a goose egg. She recovered from her confinement and two years afterward in making an examination no trace of the fibroid could be discovered. I have no doubt but that in the process of involution that took place after the birth of her child the fibroid was absorbed.

Then again the fibroid may be large and the hemorrhage has exhausted the patient to that point where surgical interference becomes exceedingly dangerous. (The patient and friends have all along fought against an operation of any sort.) Electricity has been tried, medicines of all kinds, but no favorable results follow. She is now too weak for any operative interference possible. In these cases I have seen good resulting, not only in the control of the hemorrhage, but in diminishing the tumor, by careful, thorough curretting,

Let me cite here another case, one of a number: Mrs. L, A. S., aged forty-three, married December 26, 1867, has one child twenty-two years old, no miscarriages. Family history that of phthisis on both sides. First menstruated at eleven, always regular but very painful. Fifteen years ago had typhoid fever, menstrual condition remaining about the same. In the winter of 1891 suffered from la grippe, and in April felt an enlargement in the left inguinal region which gradually increased in size, and sensitive to the touch. Soon after this she noticed a gradual increase of the menstrual flow with each period, and which continued at times quite severe. From November, 1891, until the time of her admittance to the Albany hospital, April 2, 1892, she flowed almost constantly. Bowels were constipated, and she felt the desire to pass urine every two hours. On physical examination she presented a large interstitial fibroid with a bleeding surface projecting into the cavity of the uterus. The uterine sound passed in to nearly the depth of seven inches. The tumor was only slightly movable, evidently having many attachments. Owing to her weak condition—being very anæmic, and inclined to frequent attacks of syncope—it was thought best not to attempt supravaginal hysterectomy. It was not considered advisable to encourage her in the belief that the appendages could be removed, as they probably could not. In order to put her in somewhat better condition, by controlling the hemorrhage, I recommended thorough curretting, which was done, and with satisfactory results. A portion of the exposed fibroid was removed, in this manner the hemorrhage largely controlled, and the patient very much improved, so that the latter part of June she was in a much better condition for a radical operation, although the tumor had diminished fully one-half. The case is still under observation.

Even in these desperate cases while the hemorrhage may not be permanently controlled or the tumor lessened, yet it not infrequently brings your patient in a much better condition for the more formidable operation which it is now plain to herself and friends must be done.

A class of cases that call for careful consideration are those in which the patient believes that she is passing her change of life (see my paper, "She Thought it was Her Change of Life," published in *American Journal American Medical Association*, July 5, 1890). Too many times these patients are sadly mistaken and we have yet something to teach them on this point, at least an early examination should be insisted upon.

A case that illustrates so decidedly procrastination on the part of the patient in reference to a physical examination, is exhibited in the following history: Mrs. A. G., aged fifty-six; married twenty-eight years; no children. Has never been pregnant, and always regular in her menstruation, though not at all free, the flow seldom lasting more than three days, and not excessive. I saw her August 26, 1892, with Dr. Ullman, of this city, Six years ago when in full health her menses stopped at once and gave her no serious trouble at the time. She is a hard working housewife, does much outdoor exercise, and accustomed to being on her feet a great deal, yet in no way did she suffer inconvenience from the cessation. She remained in good health until May, 1891, when she began to flow. Was somewhat disturbed in her mind about it, not thinking it to be the proper thing, still continued on about her work, though the flow kept up more or less, sometimes very severe, amounting to a hemorrhage, later occurring every four or six weeks. Dr. Ullman was called to see her first in January, 1892. Up to this time she had always opposed an examination from any physician, and even now was unwilling to have it done. Complained of more or less desire to pass water constantly, and which had been the case since July, 1891. Finally she consented to a physical examination, when the doctor found the uterus of about normal size, but on introducing the sound the flow came on very quickly, and was not easily controlled. Treatment has been that of medicines internally and local douches. For the past two months she has had much burning pain in her back and dragging sensation through the pelvis, more severe for past two weeks, a severe constipation, requiring the taking of laxatives, bowels not moving more than once

in two or three days. At the present time she looks very anæmic, is emaciated, cannot sleep, no appetite, and occasionally vomits a glairy-like, white fluid. There is some swelling of the legs, particularly of the left one below the knee, both legs presenting a condition of varicose veins, while the right one has the evidence of old varicose ulcers, Is now passing urine very frequently. On careful bi-manual examination the fundus of the uterus was found very much enlarged but the organ was somewhat movable and prolapsed, the os presented as a very small conical shape, with pin-hole opening through which the small uterine probe passed to the depth of five inches. The uterus was sensitive to the touch. There was no ulceration of the cervix, no evidence of any severe vaginitis. The patient was very anxious to have something positive done. In this case it would be very difficult, and I fear quite impossible, in consequence of the attachments of the uterus, to do a vaginial hysterectomy. I advised, therefore, a thorough, careful curretting, after complete dilatation, with a hope that it might arrest the hemorrhage and place her in a better condition of strength. This was consented to and done later, but the detritis on examination proved it to be a case of sarcoma of the uterus, with no possible chance of an operation affording her relief.

Another illustration: Mrs. T. W., aged fifty-nine, whom I saw July 3, 1889, stated that for a period of five years she had been passing through her change. She had flowed irregularly, but for the past two years had flowed quite continuously, sometimes going on for a period of four or five months. She was very anæmic and much exhausted. Upon examination I found the uterus uniformly enlarged, and presenting all the characteristic appearance of a three months' pregnancy. It was movable, not especially sensitive to the touch. Her time of life and all led one to fear malignant disease. She had been treated all this time by the taking of medicines and local washes; had quite entirely declined to have an examination at any time. Upon proper representation to herself and family, a careful examination was allowed, and the diagnosis of uterine fibroid or submucous polypi was

made. She consented to have the operation of curretting. This was thoroughly done and a large amount of detritis, made up of small polypi, granulating tissue, and such material, as is found in similar cases, removed, and the uterus well packed. The debris was carefully examined, under the microscope, and found to be made up of simply polypoid granulating tissue, non-malignant. She did well for about a period of four months when her flow returned, and the symptoms presented again in an aggravated form. I now did a second curretting more thorough and complete than at first. After this she made a permanent recovery and at the present time shows an excellent appearance of health, the uterus is quite normal in size, atrophy taking place about as it should in one at her time in life.

Another class of cases, that of advanced age. The menopause has been passed perhaps anywhere from one to ten years; a hemorrhage then appears. At first many women actually think it is a return of their menstrual periods—a sad delusion in too many cases—going on, until when once an examination is made, the diagnosis of advanced malignant disease is too apparent. Yet right here I wish to make a statement and to differ from many of our text-books. These cases are not by any means always malignant. Quite a percentage are only cases of foreign growth from the endometrium—small polypi, etc., and can be successfully treated by thorough curretting.

To illustrate this class of cases I would speak of Mrs. R., aged sixty-three who had passed her change some thirteen years before, had been in apparently good health, when suddenly she began to flow, and believed that her periods had returned. The case would naturally arouse one's suspicion as to malignant disease, and yet this was nothing more than a simple hemorrhage due to a slight endometritis, which finally passed away under treatment, and the patient continued in good health, dying at the age of seventy-five. We would naturally conclude when seeing such a case, and with truth, that the chances were she was developing a case of malignant disease.

Another case, that of Mrs. F., aged seventy-four, and whom I saw fifteen years ago in consultation with her family physician, had a flow develop some ten years after her change, and which had been a source of great alarm to herself and family. Upon examination I feared, from the hardened condition of the cervix, that it was likely to be a genuine case of carcinoma, yet on removing some of the detritis from the cervical canal, and examining it, it did not present any of the characteristic conditions of malignant growth. It was evidently a case of endometritis fungosa. Curretting was done, applications were also made to the lining membrane of the uterus, which seemed to be necessary about once in six months or once a year, and sometimes going much longer than that. At the present time she occasionally has a slight hemorrhage, but is in excellent health, has no enlargement of the organ, or infiltration of the appendages. This case has evidently been one of non-malignant endometritis fungosa.

A class of cases in which we must be careful and not place too much reliance in the use of the currette, only perhaps as a means of diagnosis and in all cases after curretting that we are at all in doubt as to the nature of the case, whether it is malignant or not, the patient should be watched with much care afterwards. The point I wish to bring out is very well illustrated in the following case:

Mrs. E. M. K., aged thirty-eight, married seventeen years; one child aged sixteen years; confinement normal; never had any serious illness; regular in her menstruation; became a widow seven years ago, married her second husband five years ago, and has been perfectly regular in her menstruation until her present trouble. Believed herself to be well, when suddenly in May, 1892, she had a severe attack of hemorrhage. She was seen by her attending physician and after a thorough course of medicine, submitted to curretting of the uterus some time the latter part of June. In July, she had, as she believed, a normal, regular, menstrual flow. Some time during July she was visited by her family physician, but no examination was made. In fact no examination was made

at any time after the curretting, as she stated. In August she had another severe hemorrhage, the local pain being now very severe, her system showing much exhaustion. She came to my office August 25, 1892, presenting the characteristic appearance of great loss of blood. I gave her a careful examination and found a large epithelial growth, implicating the entire cervix and extending somewhat down the vaginal wall. The mass was movable but there was evidently infiltration of the broad ligaments. I did not think an operation advisable. Had this case been carefully watched after the curretting it would have been apparent in a short time that vaginal hysterectomy would have been the proper operation for her, and might have resulted in permanent recovery. This patient has at various times since curretting been anxious to have another examination and the more complete operation—as she informs me— but that her female friends, the old ladies particularly, were constantly importuning her not to have anything more done, as it was simply her change of life and she would come out all right later on.

It is not to be expected that a paper of this kind will cover the subject so completely as a chapter in one of our advanced text-books, or a diadactic lecture, yet these, to sum up, are the conditions in which I would recommend the thorough use of the currette in the manner I shall presently describe:

Prolonged hemorrhage in girlhood, womanhood, adult life, advanced age.

Hemorrhage from small or large fibroids, and from hydatids.

Hemorrhage from endometritis fungosa at any time in life.

Septic conditions following miscarriage or full-term delivery.

Sub-involution—chronic metritis—acute or chronic endometritis associated with or without laceration of the cervix. Many cases of laceration of the cervix require, a short time previous to the operation for repair, a careful curretting.

Cases of painful menstruation, due to cervical stenosis, and where it is determined to wear, after dilatation, an intra-uterine stem pessary.

Cases of retro and anti-flexion, causing great enlargement of the body of the uterus.

Contra-indications are very few. Much care is necessary in curretting fibroids to recognize a thin uterine wall. If pus tubes are present, without doubt, then avoid the currette and do an abdominal section. A double uterus must be recognized, and both cavities carefully examined. These cases are, however, exceedingly rare.

I am not unmindful of the criticism that is made, and with a good line of reasoning, against invading the cavity of the uterus in the manner I have spoken of, and in the use of the currette, bnt I wish to be distinctly understood that the instrument is only to be used when followed by proper drainage, and that drainage I believe to be secured in the best possible manner by properly introduced antiseptic gauze. The kind of currette that is to be selected must receive careful consideration. The sharp and the dull instruments have both had their advocates, and I believe too much stress has been laid upon the importance of using one or the other. The manner of using the currette, the position in which the patient should be placed, all should be carefully considered. The first and necessary preparation of the patient—who is about to undergo this operation—is the importance of a thorough washing and cleansing of the external genitals, a complete bath and proper antiseptic vaginal douche. A rubber pan if possible should be employed during the time of the operation, but is not always absolutely necessary. The parts should be thoroughly scrubbed with soap and every condition of the patient put in as aseptic a state as possible. The one point next to cleanliness that I would advise above everything else, is the complete and thorough dilation of the cervical canal. This may be done by either Peaslee's steel dilators, or Hank's hard rubber uterine dilators or any of the various forms of instruments of this sort. Under ether, by their means, the cervical canal can be rapidly dilated and this is far preferable to the old method of the use of tents. If the latter are to be made use of the Laminaria or Tupello ones are preferable to the sponge tents. Seldom in septic con-

ditions following the puerperal state is dilation required. In all other cases, the patients will need it. As I have stated, dilatation by any form of tents is hardly admissible. The patient will generally require an anæsthetic, then, instruments having been placed in hot water, patient either in the recumbent position using a good bi-valve speculum with short anterior lip, or, better yet, on the left side, using a large Sim's speculum with short lip, and attention to this latter point is very necessary. Then by fixing the uterus firmly, bringing it well down to the edge of the pelvic outlet by means of the double vulsellum forceps you straighten the uterine canal in cases of flexion. Now I usually make use of the uterine sound with which to get my bearings. In cases of uterine fibroid it enables you to locate the tumor, length of uterine canal and thinness of uterine wall. Also as to multiple polypi in the uterine cavity. Next I attempt gradual dilatation with either of the aforesaid dilators. If this process is likely to prove too tedious I then make use of rapid dilatation by means of the uterine steel dilator, selecting that form of instrument in which the blades are actually parallel with each other, that the minimum of traumatism is done to the cervical or uterine tissues. When the dilatation is sufficient so that your currette will pass in and out freely, the conditions are favorable for going ahead. If the case is a septic one the dull currette will often be sufficient, and is perhaps safer than the sharp one. The instrument should be entirely of metal.

If you are curretting in cases of fibroids, chronic endometritis and like conditions, the sharp instrument is undoubtedly the surest, and the currette that has the return flow so that all the detritis can be immediately washed out and its appearance kept under observation, is by all odds the best.

As a fluid I am much in favor of using boric acid, a drachm to the pint of hot water, or Thierch's solution composed of, boric acid, four grains; salicylic acid, one grain; water, one ounce. Using only in very putrid and offensive cases the various preparations of the mercurials. The latter may be used in the strength of 1-2000 (washing freely after its use) or, safer still, 1-5000 or 1-10,000. Up to this

point the work has been thoroughly done and now a stage is reached which requires care and courage. Some five years ago I learned to know that while curretting had been of service in my cases, yet the method of drainage afterwards—using stem pessary, etc.—had not been entirely satisfactory, and I determined (though not seeing it mentioned anywhere), to make use of gauze packing to secure capillary drainage, in the same manner as I drained my cases of abdominal section through the glass drainage tube. (I would state here that in such a case as where the cervical canal shows a decided disposition to re-contract, a strong intra-uterine glass pessary is of service, packing its calibre with narrow strips of iodoform gauze, from time to time, I learned soon to pack thoroughly well the entire uterine cavity with medicated gauze, of late using almost invariably the iodoform gauze. Occasionally, in cases of constant oozing, not controlled by hot water irrigation, employing strips of sterilized gauze soaked in a solution of liquor per sulphate of iron, a drachm to four or eight ounces of water, is advisable. The strips of gauze should be cut as long as possible, without tying, and should be tried that no weak point of breakage is left. This careful packing gives good, safe drainage, and insures an aseptic condition. This packing can be done without, yet it is best to use the cervical speculum, such as I here show you, with other instruments.

One is pleased, seeing in septic conditions, the thermometer drop from 103 or 104 down to normal, and remain there, the patient going on to perfect recovery. In cases of a nasty septic condition, the packing should be removed at the end of forty-eight hours or sooner. In cases non-septic, it can be left in four or five days—perhaps not to be re-placed then when removed. Where the operation has been done to control the hemorrhage in fibroids and it shows a tendency to continue, it is well to repeat packing every three or four days, for perhaps ten days or two weeks. Frequently one curretting and thorough packing in these cases is sufficient. Yet there are some that will require not only the repeated packing, but a renewal of the curretting in one, two, three, four, six, eight or ten weeks.

In curretting in these cases I wish to be understood that it is to be done more for the purpose of controlling hemorrhage sufficiently to bring your patient into the better condition for a radical operation of entire removal of the tumor.

At the time the uterine cavity is packed, a moderate, careful packing (connected or not with the uterine gauze) of the vagina should be done. It is generally better to have the two pieces of gauze—uterine and vaginal—separate, and the ends so arranged that they can be recognized. It may be necessary soon to remove the vaginal but not the uterine portion.

Let me emphasize here that in septic cases—especially puerperal — where no improvement follows this method of treatment, we must be prepared to do abdominal section, to relieve septic conditions within the pelvic cavity, and, then failing to relieve our patient, we have to face a true case of septicæmia or sapræmia, and in which the chances are against her, but in the battle we are maintaining let us do all we can from an aseptic, antiseptic, surgical standpoint.

Permit me to say here that in these septic conditions we do wisely in giving germicides internally, such as iodine, carbolic acid, salol and the like. Clean bedding, clean floors, pure air, and the like, must never be lost sight of in these cases.

Let me say a word here regarding cases of abortion, honest or otherwise, in which we are called and find so much trouble in removing the decidua or placenta. Those of us who show the blossoming of age in our hair or beards, and I may say many younger men, will recall a case or cases where the continued hemorrhage, or the knowledge of retained detritis in some form, has given us many anxious hours and sleepless nights. Now we know that we have but to prepare our patient, to employ curretting at once and all will be well. The mighty change made by the still mightier tongue of the public, that the doctor left behind a portion of the after-birth which was the cause of death, no longer holds good. Our conscience is clearer when we have done our full duty, and the sting of the critic is lost in the recovery of our patient.